M•Plan Benefits & Services

Deductible (Waived for Non-Tobacco Users) — **Member Cost**

Single $500
Family $500

The Medical Deductible, applicable for Tobacco-Users only, does not have to be met before the following covered health care services are available at "No charge" or the Copay/Coinsurance listed below: Professional services for physician office visits; Preventative Medical Services-Type I; office visits for Mental Health/Substance Abuse services; and Pharmacy services including outpatient diabetic drugs and supplies and Nutrition for Inherited Metabolic Disease.

Copayments for these services do not accumulate toward the Medical Deductible.

Maximum Out-of-Pocket

Contract Year Maximum Out-of-Pocket per Covered Person $2,000
Contract Year Maximum Out-of-Pocket per Family $4,000

Copays/coinsurance for prescription or biopharmaceutical/injectable drugs do not count toward the satisfaction of the out-of-pocket maximum.

The Maximum Out-of-pocket does not include the Medical Deductible.

Physician Office Visits

Primary care physician office visits ..... $20 copay
Visits to specialist upon referral ..... $20 copay
Services include: Periodic physical check-ups and exams; prenatal and postnatal maternity visits; well child care and routine pediatric visits; immunizations and injections; and *Preventive Medical Services-Type I (PAP, PSA, fecal occult blood testing (FOBT), and mammogram screenings)*

Physician Non-Office Visits

Primary care, specialty and referral physician visits in hospital or other outpatient setting ..... No charge
Services include: Surgical physician or assistant, Anesthesiologist or Emergency Room physician(s)
Primary care, specialty and referral physician in-home visits ..... 20% of covered charges

Inpatient Hospital Services

Semi-private room and board ..... $500 per admission
Services include: Private room if medically necessary Operating, Recovery rooms and other special units including Intensive Care
Maternity care, hospital ancillary services including laboratory, x-ray, EKG and other diagnostic services
Other services including anesthesia, physical therapy and medications, administration of blood and blood plasma
Non-experimental organ transplants when prior authorized

Outpatient Services & Preventive Medical Services-Type II

Outpatient surgery ..... $250 per admission
Outpatient services including laboratory, x-ray, EKG other services ..... No charge
Outpatient services for MRI, CT, PET and SPECT ..... $50 copay
Emergency room facility charge for life-threatening medical emergencies ..... $75 per visit *(waived if admitted to hospital)*
Immediate/Urgent Care Center visit ..... $35 per visit

Mental Health Services

Inpatient mental health services for evaluation ..... $500 per admission
Outpatient visits for psychotherapy, crisis intervention or psychiatric testing ..... $20 copay
Psychiatric Intensive Outpatient Program (Ambulatory Level Two Mental Health Programs) ..... $20 copay

Substance Abuse Services

Inpatient substance abuse services for diagnosis and detoxification ..... $500 per admission
Outpatient visits for evaluation or crisis intervention ..... $20 per visit

Other Services

Dialysis ..... $20 copay
Durable medical equipment ..... 20% of covered charges
Emergency ambulance ..... $50 copay per transport
Family planning including infertility diagnostic testing and counseling, & sterilizations ..... 20% of covered charges
Diaphragms, cervical caps, IUDs ..... 20% of covered charges
Home health care in lieu of hospitalization ..... $20 per day
Morbid Obesity surgical services ..... 20% of covered services plus applicable inpatient or outpatient copay
Prosthetic devices and corrective appliances ..... 20% of covered charges
Rehabilitation Therapy - Physical, Occupational and Speech ..... Inpatient: $500 per admission; Outpatient: $20 copay per visit limited to 25 visits per condition per calendar year
Temporomandibular Joint Dysfunction or Disease (TMJ) when medically necessary and prior authorized ..... Applicable office visit, inpatient or outpatient copay
Transplants ..... $2,000 copay; transplant lifetime maximum benefit of $1,000,000

Prescription Drugs

Prescription drugs for up to 30-day supply. OTC Select, Generic and Select Prescription Drugs are available through the participating mail order pharmacy for two thirty (30) day supply copayments for a 90-day supply. Non-Select is available for three thirty (30) day supply copayments for a 90-day supply. To be covered, certain prescription drugs may require Prior Authorization.

OTC Select drugs ..... $ 5 copay
Generic Prescription drugs ..... $10 copay
Select Brand Name drugs including Select diabetic drugs & supplies ..... $20 copay
Non-Select Brand Name drugs ..... 40% of covered charges ($40 minimum, $100 Maximum)
Biopharmaceutical drugs/injectable drugs ..... 20% of covered charges

$1 Million Lifetime Maximum Benefit (excluding transplants) per Covered Person
$1 Million Transplant Lifetime Maximum Benefit

All services must be provided, prior authorized, or referred by the member's participating primary care physician except in cases of life-threatening emergency.

M•Plan Benefits & Services

Exclusions

- Any service not provided, arranged for, prior authorized or approved by the member's primary care physician other than for life-threatening emergency
- Any service not medically necessary
- Services for which coverage is provided or is required to be provided by law in a public/government facility
- Personal comfort items or convenience items in and out of the hospital (e.g. television, telephone)
- Skilled nursing facility, custodial care, nursing care, nursing home care, rest cures, and domiciliary care regardless of location or setting and long-term psychiatric management in any institutional or home-based setting including respite care, group homes, halfway houses and residential facilities.
- Physical exams required by a third party (e.g. employment, insurance, licensing)
- Dental services except for accidental traumatic injuries to sound natural teeth if treatment occurs within 24 hours of the accidental injury
- Conventional or surgical orthodontics
- Conventional or surgical orthognathics, unless the malocclusion is causing a persistent trauma to the gums or palate not correctable by orthodontia
- Cosmetic surgery
- Invitro fertilizations, artificial insemination and embryo transport services, GIFT and ZIFT
- Transsexual surgery; reversal of sterilization
- Marriage or sex counseling
- The evaluation or treatment of learning disabilities
- Infertility drugs
- Experimental psychiatric procedures, pharmacological regimen and associated health care services and/or those procedures that are not consistent with accepted standard medical practice or services requiring prior approval by any governmental authority prior to use where such approval has not been granted or services not approved for coverage by Medicare
- Vision care; Eye exams for contact lenses or their fitting; eyeglasses
- Hearing aids
- Chiropractic services
- Podiatry services, unless medically necessary
- Routine foot care
- Over-the-counter (OTC) drugs and supplies except those indicated as OTC Select
- Non-sedating antihistamines or low-sedating antihistamines
- Experimental health care services and drugs
- Prescription drugs for the treatment of sexual dysfunction
- Medications dispensed in a physician's office
- Allergy serum and allergy injections
- Abortion services
- Surgical treatment of infertility

Limitations

If circumstances arise beyond the control of the Plan (e.g. major disasters, epidemics); services will be rendered only as practicable within the limitations of available facilities and personnel.

If a member refuses recommended treatment for a medical condition when the primary care or referral physician and the Plan believe no acceptable alternative exists, further coverage related to that condition will be denied.

Members must use the Plan's participating providers. These providers are subject to change from time to time, and the Plan does not guarantee the length of service for any of its participating providers.

Copays

Copays are paid at the time of your office visit or when other services are received.

If you have any questions call or write:
M•PLAN CUSTOMER SOLUTIONS CENTER
(317) 571-5320 or 1-800-81-MPlan (800-816-7526)
8802 N. Meridian Street, Suite 100
Indianapolis, Indiana 46260

This brochure describes the essential features of the benefit plan and is not intended to be a full description of benefits.
The complete program is described in your employers' Group Service Agreement.
Your Certificate of Coverage is a complete description of your benefits.